



Australian Government

Comcare

Literature review into best practice for preventing and managing customer aggression

Professor Duncan Chappell

Reprinted and de-identified by Comcare

Remit, definitions, scope and approach

Remit

This report is about the measures that can be taken to prevent or manage the risks associated with this occupational hazard. It is a report commissioned by Comcare, the Commonwealth agency responsible for the regulation of occupational health and safety

[OHS] in the federal arena, and the workers' compensation insurer of numerous federal and allied agencies¹. More specifically, I have been requested as a consultant to Comcare to :

- 'Conduct a thorough literature review of current approaches in Australia and internationally in relation to preventing and managing customer aggression'.
- '..[.]identify any existing measurement tools/parameters as part of the literature review'.
- 'Provide a summary report following completion of the literature review. This report should identify best practice approaches, identify any existing measurement tools, and recommend strategies to implement best practice'.²

Definitions

The phrase 'customer aggression' is nowhere defined in the contractual documents which commissioned this literature review. In order to set the parameters of the review it is therefore important at the outset to consider the nature and scope of the behaviour encompassed by this phrase.

¹ A list of these agencies, 174 of which are Commonwealth bodies and the remaining 30 or so self-insured non-government bodies, was supplied to me by Comcare.

² See Comcare. *Request for quote. Best practice for preventing and managing customer aggression*. [RQF] Tender no. T08-15. [Undated]

A useful starting point is to be found in the sectoral activities program of the International Labour Organisation [ILO]³. The ILO, founded in 1919, is unique among agencies affiliated with the United Nations in having a tripartite structure comprising representatives of government and of employers' and workers' organisations. These three constituencies are active participants in a range of activities including the annual International Labour Conference – a world forum at which social and labour questions are discussed. From these discussions emerge international conventions, codes of practice and other recommendations on many issues including occupational violence.

In 2003 the ILO adopted a *Code of practice on workplace violence in services sectors and measures to combat this phenomenon* [ILO Code].⁴ The ILO Code is not a binding document on member states of the ILO, which includes Australia, but it has a powerful and authoritative status in setting the international agenda for dealing with violence at work, including 'customer aggression'.

For the purpose of the ILO Code the services sectors include:

'commerce; education; financial and professional services; health services; hotels, catering and tourism; media and entertainment industries; postal and telecommunications services; public service; transport; and utilities: primary and secondary industries are not included.'⁵

It will be noticed that among the list of agencies referred to above is the 'public service' which represents Comcare's primary constituency. A full list of Comcare's client base will be found in Appendix 2.

The ILO Code has the following definition of workplace violence:

'Any action, incident or behaviour that departs from reasonable conduct in which a person is assaulted, threatened, harmed, injured in the course of, or as a direct result of, his or her work.

Internal workplace violence is that which takes place between workers, including managers and supervisors.

External workplace violence is that which takes place between workers (and managers and supervisors) and any other person present at the workplace.'⁶

It will be seen that the ILO Code's definition of workplace violence incorporates both 'internal' and 'external' behaviour affecting the workplace. It is only 'external' behaviour of customers that is of interest and relevance to this report. The phrase 'client / customer' used in the ILO Code refers to 'an individual who receives a personalised service, as opposed to the general public', and includes 'patients, passengers, users or audiences'.⁷

3 See in general the ILO website at <http://www.ilo.org/public/english/dialogue/sector/>.

4 ILO Sectoral Activities Program. *Code of practice on workplace violence in services sectors and measures to combat this phenomenon*. Geneva : ILO, 2003.

5 Ibid, Clause 1.3.2.

6 Ibid, Clause 1.3.1

7 Ibid, Clause 1.3.3

These ILO Code definitions reflect in general the approach taken to this aspect of occupational violence in Australia although a current risk management guide for customer service providers, published jointly by Comcare and Centrelink, the Commonwealth's income support and related services agency, adopts a much broader definition of 'customer aggression' in the following terms:

'Any unacceptable hostile behaviour towards customer service staff that creates an intimidating, frightening or offensive situation, and/or, adversely affects work performance'.⁸

A very wide range of behaviours can still be encompassed within the forms of occupational violence more tightly defined and described in the services sectors of the ILO Code. These include at one extreme homicide, which fortunately remains a rare event in Australian workplaces⁹, to physical violence, threats, stalking, verbal abuse, and other conduct that is likely to have a psychological impact upon the victim.¹⁰ A more detailed account of such behaviours is provided later in this report.¹¹

Scope

While restricting the scope of this report to customer related aggression it is important to recognise that workplace violence is not readily categorised into neat silos of this type. The research literature indicates that the causes of violence at large are extremely complex and diverse, and that those who seek easy and simple explanations of violence occurring within the workplace will be disappointed and frustrated by their study of the subject.¹² Research shows that violence at work can result from a diverse array of interactions between a perpetrator [customer], victim [staff member as well as another customer], the physical and external environment of the workplace [security precautions, crime rates in the local area etc], the culture of the workplace [presence of bullying or harassment etc] and the nature of the work being performed [some jobs are at much greater risk than others].¹³

Briefly, perpetrators and their propensity to resort to aggression can be affected by many individual risk factors including a prior history of violence, age, gender, mental state, and use of drugs and alcohol. Victims are similarly likely to be affected by various risk factors like those of age, gender, experience on the job, health, personality and temperament. Then within the workplace there are other risk factors to be considered including the location and physical features of the environment, the managerial style and the organisational setting which can all play a role in precipitating or restricting aggressive behaviours. The task situation is also highly relevant to the risks of violence occurring – it is well established that undertaking tasks like working alone, with valuables like cash or pharmaceuticals', with people in distress, and with members of the public in service situations are all factors which enhance the risks of violence.¹⁴

8 See Centrelink and Comcare. *Applying best practice principles to the prevention and management of customer aggression. A risk management guide for customer service providers*, Canberra: Comcare, 2000; also retrieved September 5 2008 at <http://www.comcare.gov.au/publications/publications-html-version/ohs33>.

9 Information concerning homicide trends and patterns will be found at the Australian Institute of Criminology [AIC] website at <http://www.aic.gov.au/publications/rpp/77/>.

10 See in general Chappell, D. and Di Martino, V. *Violence at work* [3rd edition]. Geneva : ILO, Chapter 2 ; Mayhew, C. *Preventing client initiated violence. A practical handbook*. Canberra : AIC, 2000, pp. 7-14.

11 See the section titled Administrative Controls below.

12 See Chappell and Di Martino, op.cit., Chapter 4.

13 Ibid.

14 Ibid., Chapter 3.

It is clear that many of the risk factors mentioned above are to be found in workplaces associated with Comcare's client base. It is also apparent that with the national reach of Commonwealth agencies both the external and internal environments encountered are likely to vary significantly. For example, the social security functions performed by an agency like Centrelink are spread over more than 1000 service points nationwide.¹⁵ Most are presumably located where the greatest needs for service occur, which is often in areas experiencing an array of social problems including high unemployment, disorganised and displaced families, stress from high levels of debt, high levels of drug and alcohol abuse, and raised levels of crime. These societal risk factors are all additional matters to be considered in the risk equation for violence occurring in the Centrelink workplace.

Despite the complexities which have just been described, when seeking to explain and understand the causes of occupational violence, and measures to be taken in response, it is now widely acknowledged that this response will vary according to certain parameters set by the source of the violence. Researchers in the United States have now suggested four broad categories of occupational violence which can help assist understanding and developing prevention strategies.¹⁶ Thus the *Type 1 Criminal Intruder* category comprises incidents involving persons who have no legitimate nexus to the organisation or workplace, like robbers, thieves and other criminals. The vast majority of workplace homicides in the US [85%] fall into this category. There is no doubt that agencies within the Comcare regulatory framework are at risk from this form of occupational violence. However for the purposes of this report consideration of Type 1 incidents is not within my remit.

The second category, *Type 2 Client or Customer*, concerns perpetrators of the kind directly relevant to this report – the current or former client, patient or customer who has been the recipient of some service provided by an organisation. In the US, and in Australia, it is believed that a large proportion of client / customer incidents occur in the health sector, in settings like nursing homes or psychiatric facilities with the victims often being patient caregivers. Police, prison staff, flight attendants and teachers are also examples of workers who may be exposed to this category of violence. In the US only 3% of all workplace homicides fall within this category. The equivalent figure for Australia is even lower.

Type 3 Worker to Worker, the third category, involves incidents where the perpetrator was in some form of employment or past employment relationship with the workplace under review. This group includes co workers as well as supervisors and members of management. Again, for the purposes of this report Type 3 incidents are not part of the remit although it needs to be recognised that the forms of violence most frequently associated with this category fall under the heading of psychological violence – principally bullying and harassment – which can infect the culture of an entire workplace and influence how staff interact not only with one another but also with customers and clients. In the US about 7% of workplace homicides lie within this category. No equivalent national data is available for Australia.

¹⁵ See Centrelink. *Centrelink annual report 2005- 06. 2006*. Canberra : Centrelink, p.9.

¹⁶ US Department of Health and Human Services, Centers for Disease Control and Prevention [CDC], National Institute for Occupational Safety and Health [NIOSH]. *Workplace violence prevention strategies and research needs*. Cincinnati : NIOSH, 2006, pp. 3-6. In the mid 1990's the California's Occupational Safety and Health Administration [Cal / OSHA] developed a model that described three distinct types of occupational violence based on the perpetrators relationship to the victim and /or the place of employment. Later this typology was modified by splitting so called Type 3 violence into Types 3 and 4 - *ibid* at p.4.

Finally, the *Type 4 Personal Relationship* category involves situations where the perpetrator does not usually have any relationship with the business but does have one with the intended victim. This category, which accounts for about 5% of all US workplace homicides, includes victims of domestic violence threatened or assaulted at work.¹⁷ We currently lack any equivalent data for this group in Australia although anecdotal accounts of workplace violence suggest that family violence does on occasions intrude into Australian workplaces

Approach

Having identified some key definitional issues, and delineated the general scope of the report attention can now be turned to the approach which has been adopted in gathering relevant information for the literature review, and associated recommendations.

The literature on issues associated with occupational violence has grown exponentially during the past five years as it has become far more widely recognised that such violence should not be accepted or tolerated 'as simply part of the job' – a view which was once widely espoused, especially in the services sector. Not only has the literature base extended during this time but that literature has become spread increasingly across a number of disciplines – primarily OHS, crime prevention and criminology, psychology, and health. This disciplinary mix has not necessarily led to better interdisciplinary communication and understanding among researchers and practitioners alike. All too often communication has been channeled within traditional disciplinary boundaries as, for example, in the case of OHS specialists who until recently seem to have remained largely unaware of the criminological literature dealing with crime prevention through environmental design – the so called CPTED principles.¹⁸

A further challenge and constraint when conducting a literature search in this field is the reality that much of the 'best practice' material is not published in traditional academic journals, or even in more applied sources like the various websites of OHS agencies in this country or abroad. Such material is usually only available to a limited audience through an internal intranet or related portal of a host of agencies, both public and private. I know from personal experience when researching with the ILO that the only way in which to obtain such 'grey material' is through time-consuming and meticulous sector by sector contact and requests. With its long-established tripartite structure and connections the ILO has been able to obtain a rich and diverse range of material of this type which was incorporated into the design of documents like the ILO Code, and the books with which I have been associated over the past decade.

To assist me in my review, and to overcome so far as possible the limitations I have identified about obtaining 'grey literature', Comcare has very kindly contacted the members of an agency reference group it has established to advise it on customer aggression matters. On a confidential basis this group has forwarded a range of material for me to peruse, including guidelines and policies regarding the management and prevention of customer aggression.

¹⁷ Ibid.

¹⁸ See Mayhew, C. and Chappell, D. *Prevention of occupational violence in the health workplace*. 2001: NSW Department of Health Taskforce on the prevention and management of violence in the health workplace and the University of NSW School of Industrial Relations and Organisational Behaviour, Working Paper Series, at pp. 1-4. CPTED principles are also discussed at greater length later in this report.

In the main the overwhelming bulk of the literature referenced in the balance of this report is not this 'grey literature' but is drawn from publicly available sources, much of it published on agency websites. Footnoted references give access to the specific literature sources utilised.

In compiling this report I have also been given generous and invaluable assistance by a number of colleagues possessing an expertise in and knowledge of the issues involved in occupational violence. Their contributions are recognised in Appendix 1. It must, of course, be emphasised that I am entirely responsible for the content of this report and the views expressed in it.

Finally, in searching for and reporting upon best practice throughout this review I have assumed without discussion that in the world of OHS this incorporates the principles of risk management.

Significantly, the existing best practice guide relating to the prevention and management of customer aggression published by Comcare and Centrelink notes that :

'This Guide is consistent with the SRCC [Safety Rehabilitation and Compensation Commission] view that the most effective way to promote a healthy and safe workplace is for agencies to integrate OHS Risk Management into their core business'.¹⁹

This SRCC view is clearly in accord with those of its OHS regulatory counterparts throughout the world.

Measurement

Hazard Identification and Assessment

The initial step in developing any policies and procedures to prevent and respond to occupational violence like customer aggression is that of discovering the nature and scope of the problem to be confronted. Without information of this type it is simply impossible to construct a focused strategy that will successfully combat the hazards that are specific to a given agency or workplace.²⁰

¹⁹ Centrelink and Comcare, op. cit., at p.5.

²⁰ Rogers and Chappell, op.cit., at pp 19-20

Two fundamental questions need to be answered through this first step in the risk management process – what is the level and nature of risk within the working environment, and what policies, procedures or systems are already in place within an organisation that can assist in eliminating or minimising the risk of violence?²¹ Answering these two questions may not be a very time-consuming or complex task in a small enterprise but in larger organisations a proper assessment of the risks involved may require a major commitment of time and resources. It cannot be stressed too highly that no two workplaces are alike, or confront exactly the same hazards or levels of risk. However, extensive and broad guidance is now available to assist individuals and organisations wishing to undertake a risk assessment.²² Two examples of well constructed general risk assessment audit protocols, one drawn from Queensland²³ and the other from British Columbia²⁴ in Canada, will be found in Appendix 3.

National and International Data

Australia

In Australia, unlike a number of other countries and regions of the world, the measurement of risks associated with occupational violence has largely been confined to the individual workplace or sector rather than extending to a jurisdiction like a state, territory or nation. As a result the information available about this aspect of violence is at best fragmented and at worst non-existent. This dearth of data is undoubtedly a serious handicap for those intending to design and implement broad based occupational violence prevention policies in this country.

For reasons of both time and relevance it is not intended here to give a detailed description of what we do or do not know in Australia about the nature and incidence of workplace violence in general, or customer aggression in particular, but rather to point to several overseas sources of best practice information on this topic which indicate we need to consider collecting similar jurisdiction-based data in order to develop better national and local responses to this problem.

21 Ibid.

22 See in general Rogers and Chappell, *ibid.*, Chapter 3.

23 Queensland Government Department of Industrial Relations. Health care facility / service safety management system. Element – aggressive behaviour and prevention management. 2004. Appendix 1. Retrieved September 5 2008 at http://www.deir.qld.gov.au/pdf/whs/healthindustry_aggressive_behaviour_management.pdf

24 WorkSafeBC *Preventing violence in health care. Five steps to an effective program*. 2000. Appendix B2. Retrieved September 5 2008 at http://www.worksafebc.com/publications/health_and_safety/by_topic/assets/pdf/violhealthcare.pdf

United Kingdom

The most systematic and comprehensive nation wide data about the nature and incidence of what is termed 'workplace violence' [WPV] is gathered in the United Kingdom [UK] through three principal sources – the British Crime Survey [BCS]²⁵, RIDDOR²⁶ [Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995] and the Health and Safety Executive

[HSE] Fit3 workplace survey.²⁷ Each of these sources rely upon data captured from different places and do not measure the same aspects of work related violence.

The BCS incorporates a number of questions about WPV in its annual analysis of crime trends in the United Kingdom. Conducted jointly by the British Home Office and the HSE, the latest published survey from 2006/07 indicated that there were approximately 397000 threats of violence and 288000 physical assaults by members of the British public on workers during the 12 months prior to the interviews.²⁸ Male workers [1.9%] were more at risk of being victims of this violence than women [1.3%], with protective service occupations experiencing the highest risk of assaults with a rate of five times that of any other sub major occupational group. The BCS also estimated that in 40% of assaults at work the offender was under the influence of alcohol in the opinion of the victim while an estimated 31% of threats at work were made by someone affected by alcohol. In an estimated 16% of cases of assault the victim believed the offender was under the influence of drugs.²⁹

The relationship between offenders and victims is also captured by the BCS. In 2006/07 an estimated 56% of assaults were perpetrated by a stranger, the next highest group [17%] being clients or members of the public known to the victim through work.³⁰ The BCS estimated that in 2006/07 over one fifth [22%] of all people assaulted or threatened at work were repeat victims, experiencing three or more incidents of workplace violence during the year, while a further 14% experienced two such incidents during the year. The 2005/06 BCS also asked people in work how worried they were about being physically attacked by a member of the public while they were at their workplace. Amongst workers who had contact with the public 13% said they were very or fairly worried about assaults, while a further 16% said they were equally worried about threats of violence.³¹

As Australia has no equivalent of the BCS it remains problematic how far these BCS findings apply to this country.³² They are findings, nonetheless, which confirm the vulnerability of workers to customer based aggression; emphasise the occupational groups at highest risk which include the equivalent of a number of Comcare's client groups ; and raise troubling issues about the repeat victimisation of some workers.

25 See Health and Safety Executive [HSE]. *Violence at work. Overall scale: primary data sources*. [HSE Primary]. Retrieved September 5 2008 at <http://www.hse.gov.uk/statistics/causdis/violence/scale.htm>

26 See HSE. *Violence at work . Links and references* .[HSE RIDDOR]. Retrieved September 5 2008 at <http://www.hse.gov.uk/statistics/causdis/violence/links.htm#RIDDOR>

27 See HSE. *Violence at work . Links and references* .[HSE Ft3]. Retrieved September 5 2008 at <http://www.hse.gov.uk/statistics/causdis/violence/links.htm#Fit3>

28 HSE Primary, op. cit.

29 Ibid.

30 Ibid.

31 Ibid.

32 The primary sources of national data about crime related matters are to be found on the AIC website with links to a range of agencies. See <http://www.aic.gov.au/stats/>

RIDDOR is the second UK source of WPV information mentioned above. This source reflects the legal duty placed upon employers, self employed persons and people in control of premises in the UK to report to the HSE work related deaths, major injuries or over three day injuries, work related diseases and dangerous occurrences, and near miss accidents.³³ Similar reporting obligations presumably apply in each of the Australian OHS jurisdictions, including the Commonwealth.³⁴

In the financial year 2006/07 in the UK there were 6404 RIDDOR reported injuries caused by violence at work comprising 4 fatalities, 932 major injuries and 5468 non major injuries that resulted in absence from work for at least three days. The highest rates of death and injury were found in the minor occupational groupings of prison officers below principal officer [1187 per 100000 workers], police officers [sergeant and below][478 per 100000] and bus and coach drivers [301 per 100000]. Most RIDDOR reported incidents of WPV occurred in the services sector, reflecting the occupations with greatest risk.³⁵

I have been supplied by Comcare with summary statistics of the top ten agency claim history with customer aggression over the period from 2004 – 2008.³⁶ It will be seen that the data relates to both claims from the Australian Capital Territory [ACT] and the Commonwealth.

The ACT governmental functions are obviously very different from those of the Commonwealth, as are the various agencies undertaking public service activities within the two jurisdictions. No doubt reflecting these differences, the summary shows that throughout the period under review the incidence rate of accepted claims involving customer aggression per 1000 full time equivalent employees was significantly higher in the ACT than in the Commonwealth. The summary also shows that like the findings from RIDDOR the services sector has the highest risk of experiencing occupational violence.

The third UK source of information about WPV is the HSE commissioned Fit3 [fit for work, fit for life, fit for tomorrow] survey. This involves a total of 6000 interviews with representatives from workplaces across the full range of British industry. The third such survey was completed in February of 2008.³⁷ The 2006 survey asked workers to report whether they had experienced WPV in the last three months; the nature of that violence; and what if anything they did in terms of reporting the incidents. Sixteen per cent of respondents reported that someone had been abusive or violent towards them during this time frame, with verbal abuse being the most common [87%], followed by grabbing / pushing and hitting / punching. One third of workers who had suffered violence or abuse said they did not report the incident to management or related persons like security staff, while 51% did report the incident. The most common reasons given for non reporting were that the victim dealt with the matter themselves [44%]; it was too trivial [29%]; it was believed management would have done nothing; or concern that reporting would make things worse [9%].³⁸

33 RIDDOR, op.cit.

34 For general information concerning OHS reporting and allied obligations at the Federal level see the Comcare website at <http://www.comcare.gov.au/publications>.

35 RIDDOR, op.cit.

36 General information about the nature of claims made and the injuries involved appear in Comcare's annual reports. The most recent of these, for the financial year 2006 / 07, will be found at http://www.comcare.gov.au/__data/assets/pdf_file/0014/30452/Comcare_Annual_Report_2006-07.pdf

37 See HSE. *Fit3 survey*. 2006. Retrieved September 5 2008 at <http://www.hse.gov.uk/statistics/publications/fit3.htm>

38 Ibid.

Workers with a workplace and an employer were asked in the Fit3 survey what measures were in place to protect them from violence or abuse. The measures most commonly reported were a zero-tolerance policy on workplace violence [41%]; advice or training on how to deal with verbal abuse or violence at work [38%]; and advice or training on how to deal with bullying at work [26%]. Twenty three per cent of workers surveyed said that there were no measures of protection in place.³⁹

No equivalent exists in Australia of the Fit3 survey. However, it is generally acknowledged that occupational violence which does not involve a physical injury to the victim is infrequently reported.⁴⁰ One widely accepted estimate is that at best only one in five such incidents are reported for reasons that mirror many of those expressed by respondents to the Fit3 survey. Staff may also excuse violence because they believe a client is ill or disabled in some way; because they may fear job loss if they do complain; or because violence is so prevalent they would never be able to do their jobs if they were continually filling in forms.⁴¹

The Fit3 findings also point to some disturbing failures on the part of UK employers to meet their obligations to provide a safe work place for workers, including putting in place appropriate occupational violence preventive measures. Whether or not similar findings would emerge in an equivalent survey conducted in Australia is at this stage a matter for conjecture.

Europe

Some mention needs to be made of quite extensive survey and related measurement activities concerning workplace violence which have taken place within a European framework, rather than on a country by country basis like those just described in the UK. The Dublin-based European Foundation for the Improvement of Living and Working Conditions summarised many of these activities in an overview report published in 2003.⁴² Most do not touch directly upon the Type 2 violence associated with customers although in a European Working Conditions Survey undertaken in 2000 questions about any physical violence experienced by workers in their workplaces distinguished between violence emanating from fellow employees and violence from 'other people'.⁴³ The survey found that physical violence was experienced most in the health care and educational sectors throughout the European Union. It was also reported that physical violence was much more likely to have been inflicted by people who were not fellow employees, and most typically by customers or clients. About 4% of respondents across the European Union said that they had experienced such physical violence.⁴⁴ A country by country analysis showed that the prevalence of physical violence of this type was highest in those nations with the largest welfare service sectors, such as the Scandinavian countries, and especially in health and social care agencies.⁴⁵

39 Ibid.

40 Chappell and Di Martino op.cit at p.295; Mayhew [2000] op.cit. at p.7-8.

41 Ibid.

42 European Foundation for the Improvement of Living and Working Conditions. *Violence, bullying and harassment in the workplace*. 2006. Retrieved September 5 2008 at <http://www.eurofound.europa.eu/publications/htmlfiles/ef0482.htm>

43 Ibid., p.4

44 Ibid.

45 Ibid, pp5-6.

North America

Much of the pioneering research and development in the field of OHS measures concerning workplace violence has originated from North American sources. More will be said about this later in this review but at this point specific reference needs to be made to the major special survey of workplace violence prevention conducted jointly in 2005 by the United States [US] Bureau of Labor Statistics [BLS] and US Department of Labor for the National Institute of Occupational Health and Safety [NIOSH] which is located within the US Centers for Disease Control and Prevention [CDC].⁴⁶ The voluntary survey was administered to a stratified sample of almost 40000 US industries in both the public and private sectors. A response rate of 61% was obtained. Findings from this survey were initially released in October 2006.⁴⁷

The survey instrument used in this unique initiative can be found at the BLS website reference provided. While the instrument is obviously targeted at an American audience it is by far the most comprehensive and sophisticated instrument of its type available, and readily adaptable to comparative jurisdictions like Australia.

The survey findings are far too extensive to summarise here but they contain a wealth of policy relevant information for all levels of government as well as private enterprises of varying types and sizes. For example, the survey found that over 70% of US workplaces had no formal program or policy that addressed workplace violence. Such programs were more prevalent among larger private establishments and governments. In establishments that did have a program or policy they most frequently addressed coworker violence [82%] and customer violence [71%]. Nationally nearly five per cent of all establishments, including state and local governments, had a violent workplace incident within the 12 months prior to completing the survey. Over 128 million workers were employed at the 7.4 million establishments represented by the survey.⁴⁸

The highest percentages of all types of workplace violence were reported by US state and local governments. It was suggested that these findings were related to their work environment with these work places reporting much higher rates of contact with the public, having a mobile workplace, working with unstable or violent persons, working in high crime areas, guarding valuable goods or property, and working in community based settings more frequently than private industry.⁴⁹

46 BLS. *Survey of workplace violence prevention*. 2005. Retrieved September 5 2008 at http://www.bls.gov/iif/osh_wpvs.htm

47 BLS. *News. Survey of workplace violence prevention*, 2005. Retrieved September 5 2008 at <http://www.bls.gov/iif/oshwc/osnr0026.pdf>

48 Ibid.

49 Ibid.

Towards Better Measurement and Assessment

The measurement tools and their products which have been discussed in this section represent international best practice exercised at the highest levels of both public and private sector organisations responsible for setting the OHS agendas for government and industry groups respectively. They are tools which it is hoped offer guidance as well to those in government and industry who have as yet to develop such an agenda, based on access to detailed information about identified risks of occupational violence.

Attention is now turned to other aspects of risk management and best practice when seeking to deal with customer aggression.

Searching for best practice

Context

Impact of Crime and Tragedy

Mention was made earlier of the multi disciplinary nature of the literature relating to occupational violence, and to the way in which this literature has expanded over recent years. Before dipping further into this literary pool some historical notes are helpful in placing in context what can often be seen as a bewildering and at times confusing morass of both academic and policy orientated writing.

Academic as well as policy interest in occupational violence is quite recent. In the 1980's Poyner and Warne produced two groundbreaking studies for the HSE in the United Kingdom of violence against staff, and what could be done to prevent or minimise its impact.⁵⁰ These studies, based around a risk management model, went largely unnoticed in the non OHS world of that time.

Around the same period in the US the issue of workplace violence received massive publicity with the shooting in August 1986 of 14 people in a post office in Edmonds, Oklahoma. The perpetrator of this tragedy was a disgruntled postal worker who was facing possible dismissal. The shock of this mass murder raised public awareness to the type of incident which then became commonly associated, at least in the US, with the phrase 'workplace violence', meaning a murder or other violent acts by a disturbed or aggrieved employee or ex-employee against co workers or supervisors.⁵¹ Responses to such violent events were seen to be primarily the responsibility of the criminal justice system.

Australia also experienced a mass murder of this type in Melbourne in 1987 which led, in part, to the establishment by the then Prime Minister of a National Committee on Violence [NCV].⁵²

50 Poyner, B. and Warne, C. *Violence to staff: A basis for assessment and prevention*. London, HMSO: HSE, 1986; Poyner, B. and Warne, C. *Preventing violence to staff*. London: HSE and Tavistock Institute of Human Relations, 1988.

51 FBI Academy, Critical Incident Response Group, National Center for the Analysis of Violent Crime. *Workplace violence. Issues in response*. Quantico, Virginia : FBI, 2002, at p.11.

52 NCV. *Violence. Directions for Australia*. Canberra: AIC, 1990.

I chaired that Committee which produced a series of research studies as well as comprehensive report on ways in which violence of many types could be prevented or managed. Among the research studies was one dealing with violence experienced by 'public contact workers', and methods of combating it.⁵³

The NCV recommendations emphasised the need for a far reaching national approach to violence reduction, including an emphasis on primary prevention strategies like the development of better parenting skills and addressing social disadvantage in the community. The NCV also made many specific recommendations relating to particular aspects of violence prevention including the introduction of stringent gun control measures.

It is one of the sad ironies that so much of the national and international consciousness raising about the nature and consequences of workplace violence, and the stimulus for various reforms, has flowed from tragic criminal events like those at Edmonds, Melbourne or Port Arthur. In the US this impact of tragedy has been especially acute following the terrorist bombings of a Federal Government office building in Oklahoma City in 1995, and the shattering events of September 11 2001 when thousands of workers perished.⁵⁴ The Oklahoma bombing was the catalyst for the development by the US Office of Personnel in 1998 of what is without doubt still one of the most comprehensive and useful policy guides about dealing with workplace violence.⁵⁵ As the preface to this guide states, in words still relevant today:

'Preventing violence is a growing concern in the United States. Public interest and media attention have focused primarily on dramatic but very rare types of violence such as shootings by disgruntled employees in office buildings. Planners of workplace violence programs face the dual challenge of reducing employee anxiety about very rare risk factors while focusing their attention on more likely sources of danger. Undue anxiety about the office 'gunman' can stand in the way of identifying more significant, but less dramatic, risk factors such as poorly lighted parking lots or gaps in employee training programs. This anxiety can also make it more difficult to cope with one of the most common workplace problems – the employee whose language or behaviour frightens coworkers'.⁵⁶

53 Swanton, B. 'Violence and public contact workers' *Violence Today*, [5], 1989.

54 See Chappell and Di Martino 2000, op.cit, at pp.3-5.

55 US Office of Personnel Management, Office of Workforce Relations. *Dealing with violence at work. A guide for agency planners*. 1998. Retrieved September 5 2008 at http://www.opm.gov/Employment_and_Benefits/WorkLife/OfficialDocuments/handbooksguides/workplaceviolence/index.asp

56 Ibid, Foreword.

Impact of OHS

The 1998 US policy guide was significant in a number of ways including its adoption of risk management strategies drawn from the OHS world, rather than taking a much narrower law enforcement or target hardening approach to the threats posed by terrorism. This risk management focus is now accepted without question but in the 1990's it was by no means as widely understood or implemented in the US violence prevention field.⁵⁷ However, across the 49th parallel the Canadian OHS community was beginning to address the problems of workplace violence.⁵⁸

A description has already been given earlier of a number of the European initiatives to measure the hazards associated with workplace violence. These initiatives were all informed by OHS principles, as were those of the ILO which commenced in the mid 1990's and led eventually in 2003 to the groundbreaking ILO Code of Practice. Certainly since around the turn of the century workplace violence has assumed a predominant and much more prominent place in the OHS literature across nations, regions and continents .

Violence and Health

Another very influential and still growing disciplinary perspective on workplace violence can be found in the health sector. In 2002 the World Health Organisation [WHO] published a landmark *World Report on Violence and Health*⁵⁹ which made a strong case for a public health approach to violence – a systematic intersectoral process that concentrates on identifying ways to keep people from committing acts of violence, eliminating or limiting underlying risk factors, and reinforcing protective factors. Partner sectors participants with valuable contributions to make include education, employment, housing, justice, trade and industry and welfare. The WHO has maintained its interest in this issue, releasing this year a further report making the case for increased attention by international development agencies to violence prevention.⁶⁰

57 Ibid.

58 The Canadian Center for Occupational Health and Safety [CCOHS] is an invaluable source of contemporary information about violence at work including the publisher of what is without doubt the most comprehensive and well written general guide to prevention issues. See CCOHS. *Violence in the workplace prevention guide*. [3rd edition] 2007[?]. Ottawa: CCOHS. This guide includes sections directly relevant to the issues associated with preventing and managing customer aggression. For additional material see <http://search.ccinforweb.ccohs.ca/ccohs/jsp/search/metasearch.jsp?QueryText=violence&MaxDocs=500&ResultStart=1&SortSpec=Score+desc&hTab=2&Search.x=28&Search.y=5&Search=Search>

59 WHO. *World report on violence and health*. 2002. Retrieved September 5 2008 at http://www.who.int/violence_injury_prevention/violence/world_report/en/

60 WHO. *Preventing violence and reducing its impact: how development agencies can help*. 2008. Retrieved September 5 2008 at http://www.who.int/violence_injury_prevention/publications/violence/en/index.html

There is now compelling evidence that workplace violence can have quite profound health consequences for victims, both physical and psychological.⁶¹ Indeed, it is partly as a result of such health and allied consequences that Comcare has commissioned the current review, for an analysis of its claims data has indicated that those claims stemming from violent workplace incidents involving customer aggression are also associated with much higher costs than other types of injury producing events.⁶² I have been informed that customer aggression makes up only 2% of all accepted claims by Comcare from premium payers, but in the latest year for which statistics are available, 2006/07, the average accepted customer aggression claim cost about \$85000 compared to about \$34000 for the average of all accepted claims.⁶³

It is not immediately clear why these costs are so much higher although it is apparent from the nature of the work performed in the agencies from which such claims originate that the staff members involved have contact with potentially aggressive customers on an almost constant basis as a part of their regular job. From a number of very brief de-identified summary statements provided to me by Comcare of incidents of recently reported customer aggression it would appear that the majority involved threats rather than the actual use of violence, and when violence was resorted to it was often against property rather than an individual.⁶⁴ Even so, such incidents are obviously disturbing and distressing, especially if they are of a repetitive nature. I was not privy to information about the actual costs incorporated in any claims, such as absence from work, counseling and related medical expenses.

Apart from being encouraged to be a part of the international public health approach to violence prevention health professionals are also disproportionately the victims of violence in the course of their work. Much of this violence is inflicted by the clients of health services, with the greatest risks encountered by staff working in mental health units and emergency departments [ED]. Quite voluminous national and international research evidence to support this statement has accumulated over the past decade. For example, one large Australian study of a representative sample of 400 public health employees, which included doctors, nurses, allied health, ancillary and ambulance workers, found that over two thirds [67%] reported having been verbally abused, about 11% bullied and 12% assaulted during the previous 12 months.⁶⁵ In another Australian study researchers retrospectively reviewed violent incidents using data collected by the Australian Incident [Health] Monitoring System between July 2000 and June 2002. The greatest proportion of incidents occurred in mental health [28%] and ED [16%]. In the ED settings patients experiencing mental health problems were found to have been involved in more than one half of the violent incidents while those

61 Chappell and Di Martino, *op.cit.*, pp.136-137. See also Victorian Task Force on Violence in Nursing. *Final report*. Melbourne: Victorian Government Department of Human Service, 2005, at pp. 23-24.

62 RQF *op.cit.*

63 See Appendix 4.

64 These reports were so brief and truncated that little could be gleaned from them regarding the circumstances surrounding the violent incidents, or the injury consequences.

65 Mayhew, C. and Chappell, D. 'The occupational violence experiences of 400 Australian health workers: an exploratory study. *ANZ Journal of Occupational Health and Safety*, 2003, [19 : 6], pp. 3-43.

intoxicated from alcohol and / or drugs accounted for more than 25% of such incidents. The most common precipitant for ED violence was said to be patient dissatisfaction with staff decisions to admit or discharge from hospital. Violent incidents included the use of razor blades, scissors and blood filled syringes.⁶⁶

The levels of violence experienced by workers in the health sector has prompted the widespread development, both in Australia and abroad, of policy and guidelines designed to prevent or minimise the risks involved. For instance, at the international level the WHO, in tandem with the ILO and other health professionals' groups, has formulated and published comprehensive *Framework Guidelines for Addressing Violence in the Health Sector*⁶⁷ while nationally the Australian Nursing Federation [Victorian Branch] has published a policy and toolkit titled *Zero Tolerance [Occupational Violence and Aggression]*.⁶⁸

Available Guidance

Specific Guides

Given both the volume and scope of the multi disciplinary literature described it might be anticipated that it should contain a plethora of material offering best practice guidance on issues directly associated with preventing Type2 violence involving clients and customers. In reality, while as will be seen shortly there is such direct guidance available it is not extensive, nor often readily obtained or the subject of rigorous evaluation concerning its effectiveness.

There is a well known tendency in many fields of professional experience in Australia to presume that best practice guidance will be found somewhere beyond the borders of the country, and most likely in Europe or North America. In the case of preventing and managing customer aggression this presumption is largely incorrect – some of the seminal publications on this topic have emanated from Australian sources and most particularly from the AIC. Mention has been made earlier of the work of the NCV whose research products, compiled by the AIC, included one dealing with violence against staff. Around the same period that this report was published the AIC also produced, as part of a series of policy booklets on crime prevention issues, an excellent guide to *Protecting Counter and Interviewing Staff from Client Aggression*.⁶⁹ This guide remains available through the AIC's website and contains information which is still widely applicable to situational crime prevention measures to protect staff against aggressive clients.

A decade after this booklet appeared the AIC published a number of studies on workplace violence in its *Research and Public Policy Series*. The publications included a practical handbook titled *Preventing Client Initiated Violence*.⁷⁰ This publication is also a very valuable and unique source of guidance to practitioners about the topic under review. It too is still readily available on the AIC website.

66 Benveniste, K., Hibbert, P. and Runciman, W. 'Violence in health care: the contribution of the Australian Patient Safety Foundation to incident monitoring and analysis' *Medical Journal of Australia*, 2005, 8: 77-84.

67 ILO, International Council of Nurses [ICN], WHO, Public Service International [PSI]. *Framework guidelines for addressing workplace violence in the health sector*. Geneva: ILO, ICN, WHO, and PSI, 2002.

68 Australian Nursing Federation [Victorian Branch] [ANF]. *Zero tolerance [occupational violence and aggression] policy and toolkit*. Melbourne: ANF, 2002.

69 Swanton, B. and Webber, D. *Protecting counter and interviewing staff from client aggression*. Canberra: AIC, 1990

70 Mayhew, C. *Preventing client initiated violence. A practical handbook*. Canberra: 2000.

Beyond our shores the studies which are available about customer aggression tend to be addressed to particular sectors of the service industry, such as airlines and other forms of transport⁷¹, educational bodies⁷², and health as already stated. Many of the best practice guidelines of this type are of a proprietary and / or sensitive nature and not publicly available, including those produced for institutions like banks, large multi national corporations or security agencies responsible for the safety and protection of prominent public figures.⁷³

The union movement in many countries has been at the forefront of much of the extensive and still ongoing activity to publicise and respond to the threats to workers health and safety posed by occupational violence. Unison, for example, the UK based public service union has campaigned on this front for better worker protection from aggressive and violent clients under the mantle of the slogan, 'It's Not Part of the Job'.⁷⁴

The campaign has stressed that employers are not only required by law to develop policies to prevent violence but that there is a cost involved in failing to do so. This cost of violence can include increased absenteeism because workers are hurt, stressed or afraid; the loss of investment in training and experience when workers leave their job; and bad publicity and low morale. Unison has also noted that violence from clients remains a major occupational hazard for many of its members with physical attacks the most serious form of violence but verbal abuse and threats as well, which are far more numerous, and can have long term health effects.⁷⁵

In Scotland the Scottish Trades Union Congress [STUC] has joined with the government to promote a similar campaign which has included research on which to base an objective assessment of the extent of the problem in respect of occupation, gender, ethnicity or age. The Scottish Minister for Finance and Public Services has supported the campaign in the following words:

'No one should ever have to face violence and abuse as part of their job. Yet there is mounting evidence that many of those serving the public risk being physically assaulted or verbally attacked at their work. Every day, public service workers are confronted with hostility, aggression and even violence from their 'customer' as a matter of course. That cannot be allowed to continue.

In a world where an ever increasing emphasis is, quite rightly, placed on meeting customers needs, it is unacceptable to forget that those who help us – bus drivers, shop workers, housing officers or members of the emergency services - are people too, and deserve to be treated as such ... We need to recognise that there are exceptions to the rule that 'the customer is always right'.⁷⁶

71 See Rogers and Chappell, op.cit. at pp. 61-62.

72 A comprehensive list of published best practice guidelines for special types of occupational violence or audiences, including the education sector, will be found in Chappell and Di Martino, op.cit. pp. 182-183.

73 Through Comcare, as part of this review, I have been given access on a confidential basis to certain internal policies of the Commonwealth Bank regarding the handling of aggressive customer issues. The material includes an excellent training guide for staff as well as procedures for managing incidents of aggressive behaviour. Further, in Chappell and Di Martino, op.cit. Chapter 7, numbers of unpublished best practice guidelines obtained through ILO research sources are reviewed.

74 Unison. *It's not part of the job. Unison's guide to tackling violence at work*. 2008. Retrieved September 7 2008 at http://www.unison.org.uk/safety/pages_view.asp?did=7238

75 Ibid, p.4.

76 Scottish Executive. *Protecting public service workers. When the customer isn't always right*. 2004. Edinburgh: Scottish Executive, p. iv.

General Guides

Most of the published guidance on best practice is usually couched in more general terms to address all forms of violence likely to be encountered at a workplace following the conduct of a hazard identification and assessment audit of the form described earlier in this review. This prevention approach is in accord with well understood and applied OHS risk management procedures where appropriate control measures are only designed after such an audit has taken place.⁷⁷

Guidelines for the prevention of occupational violence emphasise repeatedly that a mix of risk control measures, applied organisation wide, are required in order to remove or minimise the threat or impact of violence. As has been stated:

‘Preparedness is the key to eliminating or minimising workplace violence incidents. Prudent employers should identify the potential risks of workplace violence in the specific operations and prepare beforehand to address specific needs during crisis times. Without a preplan and preparation for a workplace violence incident, when and if a situation arises, management and employees will have virtually no knowledge or ability to properly react to the situation and will simply be running around ‘like a chicken with its head cut off’, which can result in additional harm or damage’.⁷⁸

This cautionary advice, although issued a decade ago, remains highly relevant today, not the least because of findings like those mentioned above from the BLS survey in the US and the Fit3 survey in the UK which revealed that in many workplaces no policies were in existence to deal with workplace violence. Although we lack equivalent data at present in Australia it seems reasonable to presume that similar deficiencies may be found in this country as well. Such deficiencies not only detract from an employer’s obligation to provide a safe and secure workplace for employees but also increase the likelihood that if a serious incidence of violence were to occur it could lead to both civil and criminal liability and actions. In the intense litigious environment of the US civil law suits arising from occupational violence are already quite commonplace.

The OHS preventive approach is based on a hierarchy of preferred actions with the elimination of hazards through redesign of the work site as the preferred option, complemented by substitution with a less hazardous work process. Lowest on the list of control priorities are administrative controls such as training and warning signs. Thus when violence prevention interventions are designed, priorities identified in the ‘hierarchy of control’ must always be kept in mind.⁷⁹

Following this model it is intended first to review the guidance available regarding the redesign of the work site and the work process as it affects customer aggression, and then to consider a range of administrative controls that might be adopted.

⁷⁷ See Rogers and Chappell, op. cit.; Mayhew, C. and Chappell D [2001], op.cit.

⁷⁸ Schneid, K. *Occupational health guide to violence in the workplace*. 1998. New York: Lewis Publishers, p. 23

⁷⁹ See in general Department of Employment, Training and Industrial Relations. *Workplace health and safety risk management advisory standard 2000*. 2000. Brisbane: Queensland Government.

Workplace Design

CPTED Principles

For several decades the concept of 'crime prevention through environmental design' [CPTED], or 'situational crime prevention' as it is sometimes called, has been a widely accepted and utilised term in criminological and criminal justice circles.⁸⁰ It is a concept aimed at enhancing those aspects of building design that discourage a range of criminal activities, including violence. Risks are minimised through design or redesign of a facility and its immediate surroundings in ways that reduce the opportunity to commit a violent act. CPTED is primarily facilitated through the expertise and work of architects, engineers, builders, landscape gardeners and those who make purchasing decisions at facilities, like interior designers. The focus of attention is the building itself and its environs, including the way that the layout of fixtures and furniture can reduce the risks of victimisation.⁸¹

A good example of the way in which CPTED principles can be incorporated into an office environment is to be found in the AIC's publication *Protecting Counter and Interviewing Staff from Client Aggression*.⁸² In that guide extensive reference is made not only to physical design factors but also to organisational and social psychology studies of the behaviour of people in public spaces of various kinds, and their responses to different colour schemes, lighting, room temperatures and service practices like queuing. All such matters are among many that require analysis as a part of the design process, and which affect the degree to which the potential for aggressive behaviour may be eliminated or minimised .

Another example of the utilisation of CPTED principles is to be found in the airline industry where comprehensive guidelines exist in regard to the management of very large numbers of people through the process of checking in, boarding and disembarking at airports.⁸³ These guidelines also extend to controlling so called 'air rage' aboard aircraft in flight. The airline industry has come to realise that this type of aggression can not only be influenced by factors like the service of alcohol on a flight but also by such things as poor management of check in procedures, lengthy queuing at security check points and unexplained flight delays. Thus work practices as well as the physical layout of airport facilities become a part of the equation when considering how best to dampen or eliminate aggression among customers.⁸⁴

80 An extensive list of reference material relating to CPTED and the application of its principles to crime prevention has been compiled by the Center for Problem Orientated Policing [POP] in the US. This reference material will be found at <http://www.popcenter.org/library/CrimePrevention/>

81 Mayhew and Chappell [2001], op.cit.at p.4.

82 Swanton and Webber, op.cit.

83 See Rogers and Chappell, op.cit., pp.61-62 ; Chappell and Di Martino, op.cit. pp 180, 190.

84 Ibid.

In general CPTED concepts have been found to be very effective in limiting violence in retail establishments like banks, convenience stores, service stations and transportation hubs but their effectiveness in other settings has often not been as fully evaluated.⁸⁵ A recent comprehensive mapping exercise conducted in the UK for the HSE of the effects of workplace design on work related violence found that there were numerous sources of information, guidance and case studies available on how the design of the workplace can help to reduce the incidence of work related violence. However, most of this data was to be found not in the traditional OHS arena literature but in the arena of crime prevention. As a result CPTED concepts were often missed entirely in the planning process. Additionally, it was often not clear how well various workplace design measures had been evaluated.⁸⁶ In Appendix 4 a very helpful reference list, taken from the HSE mapping exercise, is provided to sources of contemporary information about CPTED.

Three broad principles underlie and guide CPTED - territoriality, natural surveillance and image.⁸⁷ The territoriality principle assumes that people can be encouraged to express feelings of ownership over the areas near where they work. The natural surveillance principle refers to the way in which working areas have been designed so that higher risk sections can be overlooked and watched by other people going about their normal business. Finally, the image principle refers to the deterrent impact produced by a building that appears to be well cared for. The belief is that run down premises with graffiti may attract criminal activity and offenders – a reaction sometimes called the broken windows effect.⁸⁸

Some Specific CPTED Strategies

Situational crime strategies are usually tailored to specific sites for maximum benefit. Any new building or planned refurbishments are therefore assessed for the extent to which they enhance violence prevention. Such modifications can also assist in relieving staff fears of occupational violence.⁸⁹

A detailed review of the key facets of situational crime prevention, which include target hardening, increased visibility, fittings and furniture, and protections for staff working off site or in the community, is not possible here.⁹⁰ Briefly, target hardening involves architectural or engineering design that control access to specific areas and thus make violence less likely. Specific strategies can include wider and higher counters at inquiry desks, designated 'safe' escape rooms, duress alarms, and metal detectors built into entrances. Staff working areas can also be made accessible only via key or card locks. Target hardening is especially important in areas where a threat exists from Type 1 occupational violence although it can also be necessary in high risk Type 2 situations involving customers and clients. It is also important to remember that target hardening may have unanticipated consequences as, for example, trapping workers with a violent customer in an interview room fitted with security grills and doors.⁹¹

85 See in general the POP reference material referred to above.

86 Beswick, J. *The effects of workplace design on work related violence: a mapping exercise*. 2006. Buxton [UK]: Health and Safety Laboratory.

87 Mayhew and Chappell [2001], op.cit. at p. 5.

88 Ibid.

89 Ibid.

90 See the reference material in Appendix 4 for more detailed appraisals of the application of situational crime prevention approaches in many settings.

91 Mayhew and Chappell [2001], op.cit. at p. 7.

Increased visibility or surveillance is another key element of CPTED, aimed at discouraging perpetrators of violence through improving their identification. The underlying belief is that if the risk of an offender being caught is increased, this may act as a deterrent. Thus careful design of buildings and fittings to increase visibility is a core component of an overall violence prevention strategy.

A common contemporary feature of such a strategy is the installation of closed circuit television [CCTV] in numerous places both within buildings and outside in street and other locations, including in various forms of transport. CCTV has in fact become a feature of everyday life and it has been heralded as a major weapon in the prevention of crime, despite raising significant civil liberties concerns regarding invasions of privacy. However, quite apart from these civil liberty concerns considerable doubt and disagreement exists about the effectiveness of CCTV as a crime prevention tool.⁹² A further weakness is that it is an approach that assumes perpetrators of violence think and act rationally and plan their violent acts. Clearly, this is not the case with many Type 2 customer related incidents of violence where the perpetrator may be suffering from some disability like a mental illness, or be intoxicated from the use of drugs. In situations where violence does occur CCTV can still be an invaluable tool in recording the event and providing potential evidence in any subsequent investigation.

A related surveillance element in common use is the stationing of security guards in key positions within or near premises or other locations at risk of violence or other disturbances, including robbery and other major crimes. Again, considerable doubt and disagreement exists about the effectiveness of security guards in performing this crime prevention role.⁹³ Critics suggest that security guards, most of whom are employed by private industry, are poorly paid, trained and equipped to fulfill a crime prevention function. At worst, it is said, guards may exacerbate the risks of violence by confronting potential aggressors rather than defusing a tense situation.⁹⁴

Fittings and furniture can be designed and arranged to reduce the risks of violence using the underlying principles of CPTED. A balance, to be worked out at each specific site, has to be maintained between creating a relaxed and welcoming environment for customers while ensuring the safety of staff and other clients.⁹⁵ In particular, members of the public may have heightened levels of anxiety if long waiting times are involved in the delivery of a service, requiring careful attention to features like signage and explanations for any delays in procedures in order to reduce the risks of aggression. A quite substantial literature exists regarding best practice solutions to issues like these in settings ranging from hospital emergency departments to transport waiting areas.⁹⁶

92 See in general Norris, G. and Wilson, P. 'Crime prevention and new technologies: the special case of CCTV', in Chappell, D. and Wilson, P. [eds] *Issues in Australian Criminal Justice*. 2005. Sydney: LexisNexis Butterworths, pp.409-418.

93 A range of reference material relating to studies of the use of security guards will be found at the POP site <http://www.popcenter.org/search/?cof=FORID%3A9&ie=UTF-8&q=security+guards&cx=016817335679885975849%3Agiidughzfro&sa.x=18&sa.y=8#945>.

94 Ibid.

95 Swanton and Webber, op.cit.

96 See Appendix 9

Situational crime prevention strategies can be of particular value in protecting those who work alone, off site, in mobile work places, or in community settings. The HSE in the UK has undertaken substantial analysis of the risks of violence among numbers of occupational groups, including social workers, community mental health workers, community service officers and police, all of whom fit in to this category, and published excellent case study guides to best practice in order to minimise or prevent such risks.⁹⁷ These case studies reveal in general that whatever the size, location or nature of the occupation there are many simple, practical and cost effective measures which can be used to help prevent and manage the risk of violence to lone workers. The most effective solutions usually arise from the way in which an organisation is run such as staff training, job design and changes to the physical environment. High technology and high cost security equipment is normally not required.⁹⁸

Administrative Controls

Since violence prevention does not exist independently from other components of planning each organisation needs to ensure that all workplace policies compliment each other and that the violence prevention policy and strategy is integrated with the overall strategic plan.⁹⁹ There are, however, a number of essential administrative steps that must be taken to establish a comprehensive violent prevention policy, foremost among which is settling upon the risk control strategy to be adopted.

In some workplace settings, and in particular in those in the health sector, the favoured strategy adopted has been that of a zero tolerance approach to occupational violence.¹⁰⁰ The phrase 'zero tolerance' has a mixed ancestry, emanating from a law enforcement background in the US where it was used initially to describe a type of police behaviour, and then extending to areas like the 'war on drugs' and into the education sector where zero tolerance was endorsed by the US Congress in the 1990's as an acceptable get tough approach to misbehaviour in schools. Under this strategy the emphasis was placed exclusively on punishment and exclusion of offenders.¹⁰¹

The zero tolerance approach has since leapt across the Atlantic to the UK and across the Pacific to Australia. In the UK a zero tolerance policy towards violence in the health sector was formally unveiled in 1997 and led to the establishment of what was termed a 'zero tolerance zone' in the National Health Service [NHS]. Violence against staff working in the NHS was declared to be unacceptable and would be stamped out. Staff were encouraged to press charges against assaultive patients, and those who were known to be likely to be assaultive were to be black listed and denied treatment.¹⁰²

97 See HSE website at <http://www.hse.gov.uk/violence/loneworkcase.htm>.

98 Ibid.

99 Mayhew and Chappell [2001], op.cit. at p.12.

100 See in general Holmes, C. 'Violence, zero tolerance and the subversion of professional practice', *Contemporary Nurse* 2006, 21[2] : 212-227.

101 Ibid., pp 212-213.

102 Ibid, p.215.

In Australia a zero tolerance approach to policing was discussed in the 1990's but never adopted. It was also spoken about in some official circles as a favoured drug control strategy but under fierce criticism did not replace the country's long standing harm minimisation approach to drug use. However, more recently a zero tolerance strategy has been endorsed in several health care settings, including the NSW Department of Health, along lines similar to those established in the NHS.¹⁰³

I was one of those involved in the choice of this strategy in NSW in 2002, which has since been criticised for failing, among other things, to take account of what is said to be a lack of evidence that zero tolerance policies actually work, or that they may even make matters worse. Critics of zero tolerance policies in the health sector refer in particular to the pointless pursuit of punitive and exclusionary policies against violent patients suffering from various disabilities, like mental illness and dementia, who are simply incapable of appreciating the nature and consequences of their actions. These critics also raise legal and ethical questions regarding the exclusion of certain persons from treatment.¹⁰⁴

My own feelings about the zero tolerance approach have modified since 2002. At the time I thought that the strongest possible recognition needed to be given to the view that violence should not be an acceptable part of any job, whether in the health sector or elsewhere. For too long organisations had ignored or concealed the fact that workers endured significant levels of violence and abuse from clients and customers, and an ideology of the 'customer always being right' had prevailed.

I continue to believe that such violence and abuse is completely unacceptable but I also believe that it can be addressed in ways that do not require strict adherence to zero tolerance policies.

Incidents of this type illustrate the need for persistence and vigilance on the part of organisations to ensure their risk control strategies are well developed and reviewed on a regular basis. Violence prevention experts have recommended many steps that can be incorporated in such strategies including regular violence vulnerability audits; correction of all unsafe sites and work processes; investigation and assessment of all threats; a comprehensive violence reporting system; formal identification of high risk clients and situations; post incident supports; a system to communicate with workers; increased security awareness training of all employees, supervisors and managers; development of relationships with other key agencies like police; and maintenance testing of security measures.¹⁰⁵

103 NSW Department of Health. Zero tolerance. Response to violence in the NSW workplace. Policy and framework guidelines. 2003. Sydney: NSW Department of Health

104 See Holmes op.cit. for a summary of these criticisms .

105 See Mayhew [2000] and Mayhew and Chappell [2001], op.cit., for a more detailed consideration of issues like these.

Conclusion

I have been requested to provide as a conclusion to this review a summary highlighting best practice approaches to dealing with customer aggression, identifying any existing tools to measure such aggression, and recommending strategies to implement favoured approaches.

Best Practice

Over the past decade or more violence at work at large has gained momentum as a priority issue for governments, trade unions and employers. It is an issue that can affect any organisation, regardless of its size, industry or location. As the ILO has recognised with its Code of Practice workplace violence is now a global problem, and especially so in the services sectors, like the agencies served by Comcare as an insurer. As a result employers around the world are looking for guidance for ways to protect their staff from violence of all forms.

This review has demonstrated that a vast array of guidance material is available to assist with this task. The majority of this material, however, is directed less to particular facets of occupational violence, such as that of primary interest to this review, and more towards general issues associated with its prevention and management.

Of the material which is focused most directly on what researchers have labeled *Type 2 Client / Customer* violence, some of the best practice is to be found among Australian sources, most particularly in work undertaken over the past two decades by the AIC. Throughout this time Australia has tended to favour an approach to prevention based on harm minimisation, informed by OHS principles, rather than placing reliance on policies influenced more by criminal justice trends and practices. In more recent times there has been some dialogue and controversy, especially in the health sector, about the implementation of what is termed 'zero tolerance strategies' to deal with customer aggression.

The review emphasises that a best practice approach has to be one that is multi faceted and organisation wide if violence is to be prevented or minimised. The well established OHS 'hierarchy of control' approach to managing hazards is consistent with the criminological construct of CPTED or situational crime prevention. As with other OHS problems the risk identification, assessment and control process has been shown to be effective as a prevention strategy, as well as being required by OHS legislation.¹⁰⁶

The highest priority has to be given to interventions that design out risks through adoption of CPTED principles. While in the short term such interventions may appear to be costly, in the longer term they may well be far cheaper and have far greater beneficial consequences. Other 'administrative controls' that may be adopted must be multi faceted and tailored to site specific risks. Formal and systematic evaluations are also required of all interventions to ensure they are effective.

¹⁰⁶ Ibid.

Measurement Tools

Any violence prevention strategy is only as good as the risk assessment that underlies it. Without such an assessment, or if it is performed poorly, any resulting prevention program is unlikely to address any of the hazards lurking in a workplace, and will consequentially fail to reduce the risk of violence.

Reference was made in the course of the review to a number of guidance documents which can be used to assist with a risk assessment, and two of these documents have been reproduced in Appendix 3.¹⁰⁷ Reference was also made to the lack of information available in Australia at present about the nature and scope of the risks associated with occupational violence. Such information is available, as was indicated, in other countries like the UK, US and in the European Union. This data deficiency is an obstacle to proper national policy planning in this area.

Implementation Strategies

My final task is to seek to offer some advice about how to implement best practice approaches to dealing with customer aggression.

My first and principal piece of advice is for Comcare to commission a survey of its clients to obtain the background information which in my view is essential before any sensible implementation strategies for best practice approaches can be initiated. I would also recommend that any such survey be of a wide reaching form, addressing all forms of occupational violence rather than being limited to the more narrowly focused Type 2 situations which have formed the principal focus of this review. As I have suggested above the causes of occupational violence are extremely complex. It is convenient when talking about prevention strategies to adopt the four category typology described but these categories are not entirely and mutually exclusive.

Best practice, as well as the legal obligation upon an employer to provide a safe and secure workplace, is not just to design a policy to deal with Type 2 incidents but to consider as well the other possible hazards that may exist from Type 1, 3 and 4 incidents. Indeed, an organisation which has to see clients in a high crime area may well need to match its desire to make the environment for its customers as comfortable and pleasant as possible while also considering what target hardening measures it may have to put in place to protect its staff and client base against assault by criminals entering the workplace. Similarly, a workplace that experiences significant levels of internal Type 3 violence – bullying and harassment – is less likely to present a welcoming appearance to clients, raising the possibility of precipitating client aggression as a result. Type 4 violence can also have a profound effect not only on staff involved but also on any customers who may be in a workplace at the time an incident occurs.

¹⁰⁷ See also Rogers and Chappell, op.cit at pp. 35-39

Some further justification for a survey of this type is suggested by my own experience in conducting this current literature review. As I mentioned earlier much of the best practice guidance material, or so called 'grey literature', is locked away within the organisations which have developed them, or is at a stage of development at which public access to such material may have yet to occur. The limited time available to me to conduct this review precluded any attempt to go on a systematic search for this grey literature but through one professional acquaintance to whom I spoke about the review I was told about and obtained an interim best practice manual for managing 'unreasonable complainant conduct' within the nation's parliamentary ombudsmen's offices.¹⁰⁸ This joint project of the Australian ombudsmen is said to have started its life in the NSW Ombudsman's office in 2006 when management strategies first developed in the 1980's to assist staff to better interact with complainants whose behaviour was challenging were reviewed and a new approach adopted.¹⁰⁹ In early 2007 staff from the NSW office conducted a training seminar around the country for staff in each ombudsman's office in using the new approach. The project also included a year long trial of the new management strategies with the aim of incorporating this experience into a definitive best practice manual – a process which is apparently not complete although because of very strong interest in the project an interim version of the guide has been released.¹¹⁰

This interim manual's principal focus is not upon the prevention and management of customer aggression but much of its content is directly relevant to issues which are of interest to this review, including how to handle complainant conduct that amounts to 'unreasonable behaviour'.¹¹¹ This is not the place to discuss this content in any depth but rather to emphasise how a survey of Comcare's clients would assist in the identification and capture of similar best practice grey literature. The developmental process which has been described for the preparation of the ombudsman's manual also gives some guidance in the present context about how to implement best practice strategies regarding the prevention and management of customer aggression.

In addition to recommending the conduct of a survey by Comcare I would also suggest that this survey be supplemented by some in depth case studies of reported incidents of customer aggression. These studies could be focused on the agencies already identified as those which have the most claims resulting from such incidents. The value of case studies is that they can provide context and substance to the development of best practice guides that cannot be obtained from raw statistics. In this review I have had very limited opportunities to review any case material of this type.

108 Australian Parliamentary Ombudsman. Unreasonable complainant conduct: an interim practice manual. 2007. Retrieved September 7 2008 at <http://www.ombo.nsw.gov.au/show.asp?id=456>.

109 Ibid, p.3.

110 Ibid.

111 Unreasonable behaviour includes 'displaying confronting behaviour, e.g. rudeness, aggression, threats; sending rude, confronting letters; making threats of self harm; displaying manipulative behaviour [overly ingratiating, tears, veiled threats]'. Ibid at p.13.

Comcare is to be commended for its pursuit of best practice guidance concerning the prevention and management of customer aggression. It is a pursuit which commenced well before this current review with the preparation, in association with Centrelink, of an earlier research based publication on this subject which remains a valuable and respected best practice guide.¹¹² The process of moving beyond this point to the development of an updated and more comprehensive resource of this type has been, it is hoped, assisted by the current literature review.

112 Centrelink and Comcare, op.cit.